STATE OF WYOMING
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL II EVALUATION FOR MENTAL ILLNESS

CLIENT NAME: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

MEDICAID # : _____

(IF NO MEDICAID #, LEAVE BLANK)

REFERRING NURSING FACILITY OR AGENCY: _____

PHONE #: _____

PSYCHOSOCIAL EVALUATION

PAST AND CURRENT LIVING ARRANGEMENTS:

_____

_____

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_____

_____

MEDICAL SUPPORT NEEDS:

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_____

_____

SOCIAL, FAMILY, AND DAILY LIVING SUPPORTS AVAILABLE AND NEEDED:

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_____

_____

_____

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_____

_____

RESIDENT'S ABILITY TO MANAGE PERSONAL FINANCES:

_____

_____

_____

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MENTAL ILLNESS EVALUATION

COMPLETE PSYCHIATRIC HISTORY (PSYCHIATRIC HOSPITLIZATIONS AND OUTPATIENT TREATMENT WITH DIAGNOSES, IF KNOWN). ATTACH COPIES OF PREVIOUS DISCHARGE SUMMARIES DURING PAST TWO (2) YEARS.

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EVALUATION ORIENTATION, MEMORY FUNCTION (REGISTRATION AND RECALL) AND ATTENTION AND CALCULATION

ORIENTATION:

Ask for the date (day, month, year and day of the week). Record the answer as correct or incorrect.

_____

Ask the client, "Can you tell me the name of this hospital or location where you are currently?" Record the answer as correct or incorrect.

_____

REGISTRATION:

Ask the client if you may test their memory. Then say the names of four unrelated objects, clearly and slowly, about one second for each. After you have said all four, ask the client to repeat them. This first repetition determines the score (0-4). If the client does not repeat all four words correctly on the first try, continue to say the words (up to six trials). If the client does not eventually learn all four, recall cannot be meaningfully tested. Record score and number of trials.

_____

ATTENTION AND CALCULATION:

Ask the client to begin with 100 and count backwards by 7. Stop after five subtractions (93, 86, 79, 72, 65). Score the total number of incorrect answers. If the client cannot or will not perform this task, ask the client to begin with 20 and count backwards by 3. Stop after five subtractions (18, 15, 12, 9, 6). Record the number of incorrect answers.

_____

RECALL:

Ask the client if he/she can recall the four words you previously asked him/her to remember. Score 0-4 for correct answers given.

_____

DESCRIPTION OF CURRENT ATTITUDES AND OVERT BEHAVIORS:

_____
_____
_____
_____
_____
_____
_____
_____

AFFECT:

_____
_____
_____
_____
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_____

SUICIDAL/HOMICIDAL IDEATION:

_____
_____
_____
_____
_____

DEGREE OF REALITY TESTING (PRESENCE AND CONTENT OF DELUSIONS AND HALLUCINATIONS):

_____
_____
_____
_____
_____
_____
_____

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SUMMARY OF CLIENT'S POSITIVE TRAITS, WEAKNESSES AND NEEDS:

_____
_____
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EVALUATORS SUMMARY:

In accordance with criteria in DSM IV, this client has the following diagnosis:

DIAGNOSIS	DSM CODE	PRIMARY	SECONDARY
DIAGNOSIS	DSM CODE	PRIMARY	SECONDARY
DIAGNOSIS	DSM CODE	PRIMARY	SECONDARY

If the client **DOES NOT** have a primary diagnosis of dementia, but **DOES** have a primary or secondary diagnosis of a serious mental disorder*, the client:

_____is _____is not experiencing an acute episode of this serious mental disorder.

_____does _____does not require specialized services (the level of services provided in an institution for mental diseases or an inpatient psychiatric hospital).

_____is _____is not dangerous to self or others.

Major Mental Illness: The definition for MI under these regulations is a psychiatric disorder of thought and/or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life (Schizophrenia, Depression, Major Affective Disorders, Schizoaffective Disorders, Atypical Psychosis, including any other DSM-IV Psychotic Disorder. **Excludes**: Dementia, Alzheimer's Disease, Alcoholism, Substance Abuse, Mood Disorders or delirium due to General Medical Condition, Epilepsy, Mental Retardation, and Developmental Disorders).

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If specialized services for mental health (the level of services provided in psychiatric inpatient) are needed, identify all of these services to meet client's needs, regardless of availability of those services.

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If specialized services for mental health are **NOT** needed, but client needs (or is receiving) other **mental health** services, list below:

_____

_____

_____

_____

COMMENTS:

_____

_____

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_____

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_____

Date of Evaluation Evaluator's signature

_____

Mental Health Center

PRINT NAME AND DEGREE: _____

Instruction to CMHC: Complete supplemental for 30 Month Rule (if it applies) and submit all evaluation materials to the SMHA.

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PSYCHIATRIC REVIEW

Based on medical, psychosocial, and mental illness evaluation, I certify that this client _____is _____is not experiencing an acute episode of a serious mental disorder* and that the client _____does _____does not need specialized services (the level of services provided in psychiatric inpatient facilities.

DISCUSSION:

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DSM IV AXIS I Diagnosis and Code:_____

DSM IV AXIS II Diagnosis and Code:_____

_____

Date of Evaluation Physician's Signature